TRIPLE MARKER PROFILE (MSAFP/b-hCG/uE3) SCREENING TEST

AIR FORCE INSTITUTE FOR ENVIRONMENT, SAFETY, AND
OCCUPATIONAL HEALTH RISK ANALYSIS (AFIERA)
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PRIVACY ACT STATEMENT: This form is subject to the Privacy Act of 1974 - Use Blanket PAS - DD Form 2005

Instructions: *All information on this form is mandatory.*

1. PATIENT NAME (LAST, FIRST, MI)		2. DOB	3. FMP
4. SSAN	5. SUBMITTING BASE	6. BASE PROVIDER	7. BASE SPECIMEN NO.

26484	TRIPLE MARKER PROFILE	SERUM

THE FOLLOWING INFORMATION IS MANDATORY FOR THE INTERPRETATION OF RESULTS

8. CHECK ONE ONLY ☐ 1ST TEST ☐ 1ST REPEAT ☐ 2ND REPEAT

9. DATE SAMPLE COLLECTED: _____ / _____ / _____
Month Day Year

10. GESTATIONAL AGE DETERMINED BY: *(Indicate one method only)*

a. LMP _____ / _____ / _____
Month Day Year

b. EDC BY LMP _____ / _____ / _____
Month Day Year

c. *ULTRASOUND ON _____ / _____ / _____
Month Day Year

* IF CHOOSING "10c" ABOVE YOU MUST PROVIDE
GESTATIONAL AGE BY ULTRASOUND ON DATE OF SCAN

_____ / _____
Weeks Days

d. EDC BY ULTRASOUND _____ / _____ / _____
Month Day Year

11. MOTHER'S WEIGHT IN POUNDS (On or around collection date)

LBS: _____

12. MOTHER'S RACE

☐ BLACK ☐ WHITE

☐ OTHER (Includes Hispanic, Oriental, etc)

_____

13. MULTIPLE GESTATIONS (Check one only)

☐ SINGLE ☐ TWINS

☐ TRIPLETS

14. IS PATIENT INSULIN DEPENDENT DIABETIC?

☐ YES ☐ NO

☐ UNKNOWN

15. IMMEDIATE FAMILY HISTORY OF NEURAL TUBE DEFECTS (NTD) (Check one)

☐ YES ☐ NO

☐ UNKNOWN